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| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION | 1. TRANSMITTAL NUMBER: 04-07 | 2. STATE Louisiana |
| | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE March 21, 2004 | |

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

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| 6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440.70 | 7. FEDERAL BUDGET IMPACT: a. FFY <u>2004</u> \$0.00 b. FFY <u>2005</u> \$0.00 |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Item 4b, Page 4 Attachment 3.1-A, Item 7, Page 1 + 2 Attachment 3.1-A, Item 7, Pages 2, 3 Attachment 3.1-A, Item 7, Page 4, (Pg. 5 Removed) Attachment 4.19-A, Item 7, Page 3 Attachment 4.19-A, Item 7, Page 1a Attachment 4.19-A, Item 7, Pages 4, 5 Attachment 3.1-A, Item 4b, Page 8 | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same (TN 97-22) Same (Pending TN 04-05) 45-14 Same (TN 00-47) Same (TN 03-17) Same (TN 03-20) Same (TN 03-23) Same (TN 00-47) Same (TN 00-12) |

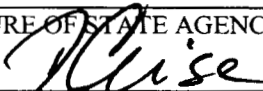
10. SUBJECT OF AMENDMENT: **The purpose of this amendment is remove the homebound criteria for home health services and establish medical necessity criteria including provisions for infants and toddlers. and describe reimbursement for extended nursing and/or multiple daily nursing visits for recipients up to age 21**

11. GOVERNOR'S REVIEW (Check One):

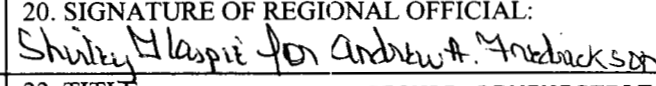
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

The Governor does not review state plan material.

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| 12. SIGNATURE OF STATE AGENCY OFFICIAL:  | 16. RETURN TO: State of Louisiana Department of Health and Hospitals 1201 Capitol Access Road PO Box 91030 Baton Rouge, LA 70821-9030 |
| 13. TYPED NAME: Frederick P. Cerise, M.D., M.P.H. | |
| 14. TITLE: Secretary | |
| 15. DATE SUBMITTED: March 29, 2004 | |

FOR REGIONAL OFFICE USE ONLY

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| 17. DATE RECEIVED: 31 MARCH 2004 | 18. DATE APPROVED: 22 JUNE 2004 |
| PLAN APPROVED - ONE COPY ATTACHED | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 21 MARCH 2004 | 20. SIGNATURE OF REGIONAL OFFICIAL:  |
| 21. TYPED NAME: ANDREW A. FREDRICKSON | 22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIV OF MEDICAID & CHILDREN'S HEALTH |

23. REMARKS:

**Pen + Ink Changes per state's e-mail dated 5/27/04.
Pen + Ink Changes per state's e-mail dated 5/28/04.**

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED

LIMITATIONS ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED
MEDICAL AND REMEDIAL CARE AND SERVICES DESCRIBED AS FOLLOWS

CITATION
42 CFR
440.70

Medical and Remedial Care and Services
Item 7.

Home Health Services

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| STATE <u>Louisiana</u> | A |
| DATE REC'D <u>3-31-04</u> | |
| DATE APPV'D <u>6-22-04</u> | |
| DATE EFF <u>3-21-04</u> | |
| HCFA 179 <u>04-07</u> | |

- A. Home health services are patient care services provided in the patient's home under the order of a physician that are necessary for the diagnosis and treatment of the patient's illness or injury, including one or more of the following services: nursing as defined in the State's nurse practice act, physical therapy; speech pathology and audiology services; occupational therapy, home health aide services; or medical supplies, equipment, and appliances suitable for use in the home. Residence does not include a hospital or a nursing facility.
- B. Home health services shall be based on an expectation that the care and services are medically reasonable and appropriate for the treatment of an illness or injury, and that the services can be performed in the recipient's place of residence. A written plan of care for services shall be evaluated and signed by the physician every 60 days. This plan of care shall be maintained in the recipient's medical records by the home health agency.
- C. Medical Necessity Criteria for Medicaid Recipients
- Medical Necessity for home health services is determined by the recipient's illness and/or functional limitations. All home health services shall be medically reasonable and appropriate. To be considered medically reasonable and appropriate, the care must be necessary to prevent further deterioration of a recipient's condition regardless of whether the illness or injury is acute, chronic or terminal. The services must be reasonably determined to:
1. diagnose, cure, correct or ameliorate defects, physical and mental illness, and diagnosed conditions or the effects of such conditions: or
 2. prevent the worsening of conditions, or the effects of conditions, that:
 - (a) endanger life or cause pain;
 - (b) result in illness or infirmity; or
 - (c) have caused, or threatened to cause, a physical or mental dysfunction, impairment, disability, or developmental delay; or

TN# 04-07
Supersedes

Approval Date 6-22-04

Effective Date 3-21-04

TN# 97-22

SUPERSEDES: TN- 97-22

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE OF LOUISIANA

Attachment 3.1-A
Item 7, Page 2

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED

LIMITATIONS ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED
MEDICAL AND REMEDIAL CARE AND SERVICES DESCRIBED AS FOLLOWS

3. restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury or condition.

The following circumstances are not considerations when determining medical necessity for home health services:

1. inconvenience to the recipient or the recipient's family;
2. lack of personal transportation; or
3. failure or lack of cooperation by a recipient or a recipient's legal guardians or caretakers to obtain the required medical services in an outpatient setting.

D. Provisions for Infants and Toddlers

Infants and toddlers are defined as young children, up to age 3, who have not learned to ambulate without assistance. Home health services are considered to be medically necessary for an infant or toddler when the primary care physician has advised against removing the infant or toddler from the home because it would:

1. place the infant or toddler at serious risk of infection;
2. greatly delay or hamper the recovery process;
3. cause significant further debilitation of an existing medical condition or physical infirmity;
4. seriously threaten to cause or aggravate a handicap or a physical deformity or malfunction;
5. cause great suffering or pain;
6. seriously endanger the well being of the infant or toddler; or
7. otherwise be considered medically contraindicated.

The following circumstances are not considered when determining the medical necessity of home health services for infants and toddlers:

1. the provision of services in the home is solely a matter of convenience;
2. a lack of personal transportation; or
3. failure or lack of cooperation by the child's legal guardian(s) to obtain the required medical services in an outpatient setting.

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| HCFA 179 <u>04-07</u> | |

TN# 04-07

Supersedes

TN# 97-22

Approval Date 6-22-04

Effective Date 3-21-04

SUPERSEDES: TN- 97-22

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE OF LOUISIANA

Attachment 3.1-A
Item 7, Page 3

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED

LIMITATIONS ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED
MEDICAL AND REMEDIAL CARE AND SERVICES DESCRIBED AS FOLLOWS

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| E. | |
| A | |
| STATE | <u>Louisiana</u> |
| DATE REC'D | <u>3-31-04</u> |
| DATE APP'D | <u>6-22-04</u> |
| DATE EFF | <u>3-21-04</u> |
| HCFA 179 | <u>04-07</u> |

Limitations on Home Health services are as follows:

1. Home health services are limited to 50 skilled nursing and/or aide visits, one service per day for recipients who are 21 years of age and older.
2. The service limitation in E.1. above is not applicable for recipients who are from birth up to the age of 21. However, home health services provided to recipients up to the age of 21 are subject to post-payment review in order to determine if the recipient's condition warrants high utilization.
3. the service limitation of 50 home health visits per year is not applicable for physical therapy, occupational therapy, or speech pathology and audiology services.
4. For Title XVIII/Title XIX (Medicare/Medicaid recipients), the Bureau of Health Services Financing will make payment for aide visits if only aide visits are required, subject to the 50 visits per calendar year limitation.

EPSDT RECIPIENTS ARE EXCLUDED FROM SERVICE LIMITATIONS

Item 7.a. Intermittent or part-time nursing services provided by a Home Health Agency.

Skilled nursing services are nursing services provided on a part-time or intermittent basis by a registered nurse or licensed practical nurse that are necessary for the diagnosis and treatment of a patient's illness or injury. These services shall be consistent with:

1. established Medicaid policy;
2. the nature and severity of the recipient's illness or injury;
3. the particular medical needs of the patient; and
4. the accepted standards of medical and nursing practice.

Item 7.b. Home Health Aide Services provided by a Home Health Agency.

Home health aide services are direct care services to assist in the treatment of the patient's illness or injury provided under the supervision of a registered nurse and in compliance with the standards of nursing practice governing delegation, including assistance with the activities of daily living such as

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TN# 95-14

SUPERSEDES: TN- 95-14

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE OF LOUISIANA

Attachment 3.1-A
Item 7, Page 4

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED

LIMITATIONS ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED
MEDICAL AND REMEDIAL CARE AND SERVICES DESCRIBED AS FOLLOWS

mobility, transferring, walking, grooming, bathing, dressing or undressing,
eating, or toileting

Item 7.c. Medical supplies, equipment, and appliances suitable for use in the home.

Medical supplies are allowable if recommended by the physician as medically
necessary for the eligible individual and suitable for use in the home. Prior
authorization is required for the purchase of all equipment and appliances.

Item 7.d. Physical therapy, occupational therapy, or speech pathology and audiology
services provided by a Home Health Agency.

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| STATE <u>Louisiana</u> | |
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1. Physical therapy services are rehabilitative services necessary for the treatment of the patient's illness or injury, or restoration and maintenance of function affected by the patient's illness or injury. These services are provided with the expectation, based on the physician's assessment of the patient's rehabilitative potential, that the patient's condition will improve materially within a reasonable and generally predictable period of time, or that the services are necessary for the establishment of a safe and effective maintenance program.
2. Occupational therapy services are medically prescribed treatment to improve or restore a function which has been impaired by illness or injury, or to improve the individual's ability to perform those tasks required for independent functioning when the function has been permanently lost or reduced by illness or injury.
3. Speech pathology and audiology services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities, and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of a communication disability

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SUPERSEDES TN- 00-47

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE OF LOUISIANA

ATTACHMENT 4.19-B

Item 7, Page 1

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION Medical and Remedial Home Health Services
42 CFR 447.201 Care and Services
Item 7.

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| STATE <u>Louisiana</u> | A |
| DATE REC'D <u>3-31-04</u> | |
| DATE APP'VD <u>6-22-04</u> | |
| DATE EFF <u>3-21-04</u> | |
| HCFA 179 <u>04-07</u> | |

- Item 7.a. Intermittent or part-time nursing services provided by a home health agency
- Item 7.b. Home health aide services provided by a home health agency
- Item 7.c. Medical supplies, equipment and appliances suitable for use in the home
- Item 7.d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency

I. Method of Payment

- A. Intermittent or part-time nursing services provided by a home health agency and home health aide services provided by a home health agency will be reimbursed using a prospective payment methodology based on the audited 1992 cost reports at the weighted thirtieth (30th) percentile based on cost and number of services trended forward at July 1 of each preceding year using the Consumer Price Index - All Urban Consumers (Southern Region). Reimbursement for nursing services provided by a licensed practical nurse (LPN) is made at 80 percent (80%) of the established fee for nursing in effect as of January 31, 2000. Nursing services provided by a licensed registered nurse (RN) will continue to be reimbursed at the established fee in effect as of January 31, 2000.

Home health extended nursing and/or multiple daily nursing visits for recipients up to age 21 are reimbursed according to a published fee schedule. Private and public providers will be paid the same rates.

- B. Rates for physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency are calculated using the base rate from fees on file in 1997. The maximum rates are set using the State maximum rates for rehabilitation services plus an additional 10%.
- C. Rates for physical therapy, occupational therapy, or speech pathology and audiology services provided to recipients up to the age of three are as follows:

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| Initial Speech/Language Evaluation | \$70.00 |
| Initial Hearing Evaluation | \$70.00 |
| Speech/Language/Hearing Therapy 60 minutes | \$56.00 |
| Visit with Procedure(s) 45 minutes | \$56.00 |
| Visit with Procedure(s) 60 minutes | \$74.00 |

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Supersedes

TN# 02-17

SUPERSEDES TN- 02-17

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE OF LOUISIANA

ATTACHMENT 4.19-B
Item 7, Page 1a

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

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| Visit with Procedure(s) 90 minutes | \$112.00 |
| Procedures and Modalities 60 minutes | \$74.00 |
| PT and Rehab Evaluation | \$75.00 |
| Initial OT Evaluation | \$70.00 |
| OT 45 minutes | \$45.00 |
| OT 60 minutes | \$60.00 |

Rates for additional physical therapy, occupational therapy, or speech pathology and audiology services provided to recipients up to the age of three are as follows.

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| Physical Therapy, one modality | \$37.00 |
| Physical Therapy, 2 or more modalities | \$56.00 |
| P.T. with 1 or more procedures, and/or Modalities, 15 minutes | \$18.50 |
| P.T. with procedures, 30 minutes | \$37.00 |
| P.T. with procedures, 75 minutes | \$92.50 |
| Occupational Therapy, 15 minutes | \$15.00 |
| Occupational Therapy, 30 minutes | \$30.00 |
| Speech and Hearing Therapy, 15 minutes | \$14.00 |
| Speech and Hearing Therapy, 30 minutes | \$28.00 |
| Speech and Hearing Therapy, 45 minutes | \$42.00 |
| Speech and Hearing Therapy, 60 minutes | \$56.00 |

II. Standards for Payment

- A. For items 7.a., 7.b., 7.c., 7.d., see Attachment 3.1-C regarding standards and methods of assuring high quality care.

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| HCFA 179 <u>04-07</u> | |

SUPERSEDES TN# 03-23

TN# 04-07 Approval Date 6-22-04 Effective Date 3-21-04

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TN# 03-23

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
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Attachment 4.19-B
Item 7, Page 3

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

D. Medical Necessity Criteria for Medicaid Recipients

The Bureau will provide reimbursement for approved home health services for Medicaid recipients based upon the certification of a licensed physician and a determination by the Medicaid agency that the recipient meets the medical necessity criteria outlined in Attachment 3.1-A, Item 7. C.

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SUPERSEDES TN 95-20

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